

## Delivering reform in English healthcare

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## **Delivering reform in English healthcare: an ideational perspective**

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### **Abstract**

A variety of perspectives has been put forward to understand reform across healthcare systems. Recently, some have called for these perspectives to give greater recognition to the role of ideational processes. The purpose of this article is to present an ideational approach to understanding the delivery of healthcare reform. It draws on a case of English healthcare reform – the Next Stage Review led by Lord Darzi – to show how the delivery of its reform proposals was associated with four ideational frames. These frames built on the idea of “progress” in responding to existing problems; the idea of “prevailing policy” in forming part of a bricolage of ideas within institutional contexts; the idea of “prescription” as top-down structural change at odds with local contexts; and the idea of “professional disputes” in challenging the notion of clinical engagement across professional groups. The article discusses the implications of these ideas in furthering our understanding of policy change, conflict and continuity across healthcare settings.

### **Introduction**

A variety of perspectives has been put forward to understand reform across healthcare systems. Starke (2010) suggests these have explained such policy

developments with reference to socioeconomic demand-side factors (Newhouse, 1977); policy transfer and policy learning (Greener, 2002; Be land, 2005); and institutional and path dependency approaches (Wilsford, 1994; Greener, 2005, 2006; Giamo and Manow, 1999). Despite these various contributions, some have recently suggested the health policy community could draw from a wider range of social science literature (Starke, 2010; Be land, 2010). They call for a shift in focus from exploring 'how institutions evolve' (Thelen, 2004; Streeck and Thelen, 2005; Hacker, 2004) to analysing the relationship between ideas and policy change (Be land, 2007, 2010). Be land (2010) has argued that drawing attention to ideas can fill the explanatory gaps of historical institutionalism, enabling us to better understand the way policy actors perceive their interests and the environment in which they mobilise. Studying this interaction between ideational and institutional processes extends our understanding about the nature of policy change (Be land, 2010: 617).

The purpose of this article is to present an ideational perspective that considers the process by which ideas are conveyed, adopted and adapted in healthcare settings (Schmidt, 2008). It moves from existing focus of how ideas shape national and transnational policy change and development (e.g. Be land, 2007, 2009, 2010; Kettel and Cairney, 2010; Harrison and Wood, 1999) to study how ideas shape policy delivery. Such an examination of the ideas professionals employ to navigate their way through the reform process can shed important light on the governance of healthcare (Greener and Powell, 2008). It has the potential for giving new insights into the long-standing disagreements between medicine, management, policy makers and the professions; how different actors in healthcare frame policy in different ways across different institutional settings.

The article begins with an overview of healthcare reform in England, with a particular focus on the case under analysis—the Next Stage Review led by Lord Darzi. Following an overview of the methodological approach taken, the article then presents four ideational frames associated with delivering reform. These set out the idea of “progress” in reform proposals with problem-solving potential; the idea of “prevailing policy” focused on the reform proposals forming part of a bricolage of ideas within institutional contexts; the idea of “prescription” challenged the reform proposals as a top down approach at odds with institutional contexts; and the idea of “professional disputes” challenged reform proposals that symbolised clinical engagement across professional contexts. The article then goes on to critically assess the

implications of these ideas in furthering our understanding of policy change, conflict and continuity in the delivery of health-care reform.

## **Healthcare reform in England**

Studying healthcare has a long history documenting top-down policy change and bottom-up professional practice (e.g. Klein, 2010). This has been no more so than in the English National Health Service (NHS), particularly over the past 10 years. In England, the New Labour government (1997–2010) introduced a variety of policy levers and incentives designed to improve quality, patient experience, and value for money (Millar et al., 2012; Stevens, 2004; Greener, 2004; Nicholson, 2009) that increased regulation, encouraged supply side quasi-markets and encouraged greater integration across health and social care services. A wide range of studies have ensued drawing attention to the range of reform policies, from the ‘targets and terror’ associated with policies to increase performance measurement (Bevan and Hood, 2006) to the market-based reforms encouraging greater competition and patient choice (e.g. Mays et al., 2011).

In 2007, the Secretary of State for Health announced a review of these reform policies. The Next Stage Review (NSR) was to be led by Professor the Lord Ara Darzi KBE, the newly appointed Parliamentary Under Secretary of State at the Department of Health. Lord Darzi was a London-based consultant surgeon who had previously advised the government on policy and led a review of service reconfiguration for the London area (NHS London, 2007). The overall brief for this review was to present a vision for how the NHS could be improved (Department of Health, 2007). This vision was to be shaped by a consultation process with patients, carers and the general public about what NHS services wanted. In all, 2,000 clinicians and other staff participated in these regional consultations (House of Commons Health Committee, 2009: 11).

The NSR process culminated in the final document *High Quality Care for All: Next Stage Review Final Report* (Department of Health, 2008). This set out a renewed vision built on ‘patients with more information and choice, working in partnership and quality of care’ (Department of Health, 2008: 7). The key message was that whilst previous phases of investment and reform had improved the NHS, greater emphasis was needed in moving the focus of reform onto ‘improving the quality of care’ (Department of Health, 2008: 4). The most significant proposal was improving the quality of treatment and clinical outcomes. In contrast with previous top-down performance measures and targets, the NSR made the case for a new approach: improving quality by

measuring both the way that treatment is provided (clinical process) and the effectiveness of the treatment (patient outcomes). This included the creation of PROMs (patient-reported outcome measures) designed to measure patients' experience, and Quality Accounts acting as financial incentives to improve quality by rewarding providers for improved outcomes (House of Commons Health Committee, 2009: 29).

Alongside quality, the NSR also encouraged greater choice and personalisation in primary care along with improved leadership and stronger partnerships between different clinicians and managers. Proposals included an NHS Constitution that set out the commitment to patients, public and staff in the form of rights to which they are entitled, the development of personalised care plans and the piloting of personal budgets to make healthcare systems more responsive to individual needs (House of Commons Health Committee, 2009: 36, 44). The proposals also included the introduction of general practitioner (GP)-led health centres (also referred to as "polyclinics") to increase the capacity of community based services. These centres were a development of the recommendation Lord Darzi made in his review of London that the development of polyclinics could provide a wider range of community based provision (NHS London, 2007).

A variety of in-depth studies of New Labour's health policies was produced that showed how the enactment of reform was shaped by local contexts that determined the eventual services on the ground (e.g. Dixon and Jones, 2011; Powell et al., 2011; Checkland et al., 2009; Coleman et al., 2010). However, the NSR appears to have been less well documented. This was the latest in a long line of reviews undertaken in the NHS going back to the Dawson Report in 1920, but was seen as different from its predecessors in way it was built on consultation with clinicians and patients and its call for a stronger focus on outcomes rather than structural reorganisation (House of Commons Health Committee, 2009: 16). The NSR was also significant in the fact it was led by Lord Darzi. As a clinician, but also an academic and policy advisor, Lord Darzi was presented as a policy entrepreneur outside of the formal governmental system who looked to introduce, translate, and implement ideas and proposals into the NHS (Oborn et al., 2011; Roberts and King, 1991; Oliver and Paul-Shaheen, 1997).

Since the time of its publication in 2008, we have witnessed further reform with the election of a new Coalition government. The Health Act (2009) that took forward many of the NSR proposals has now been superseded by a new Health and Social Care Bill. Although the NSR may have now been swept aside,

the policy proposals still appear to be of relevance. The Coalition government's White Paper acknowledges that it builds on 'the importance of Lord Darzi's work, in putting a stronger emphasis on quality' (Department of Health, 2010: 8). Indeed, Lord Darzi himself supported the new government reforms based on the belief that the proposals 'recast' the reforms in the direction of the NSR in their promotion of better professional engagement, choice, and improved quality of care (Lord Darzi, 2011). The NSR proposals therefore still form part of reform agendas in the English NHS. How these are interpreted and delivered has wider implications for our understanding of healthcare reform.

### **Understanding healthcare reform: Bringing in ideational processes**

Our interest in the NSR is to study the ideational processes associated with delivering its reform proposals. Defining such ideas is no easy task. As Beland (2010) suggests, there are many ideas about ideas (Goodin and Tilly, 2006; Jabko, 2006; Blyth, 2002). They may define 'claims about descriptions of the world, causal relationships, or the normative legitimacy of certain actions' (Parsons, 2002: 48). They may be represented in narratives that shape understandings of events (Roe, 1994) or as 'frames of reference' (Jobert, 1989). Recent definitions tend to focus on ideas as representing 'the substantive content of discourse' (Schmidt, 2008) or as 'interpretive frameworks' that people share about beliefs, goals, values and strategies (Beland and Cox, 2011: 3).

Schmidt (2008) suggests the presentation of ideas can occur at three levels of generality: policies (or policy solutions); programmes (cast as underlying assumptions/principles/paradigms that reflect frames of reference that enable policy actors to (re)construct or (re)situate themselves); and philosophies (worldviews that underpin policies and programmes with organising ideas, values, and principles of knowledge and society; see also Metha, 2011). These different levels of ideas often contain two types of ideas: cognitive and normative. Cognitive ideas (sometimes called causal ideas) provide the recipes, guidelines, and maps for political action and serve to justify policies and programmes by speaking to their interest-based logic and necessity (see Jobert, 1989; Hall, 1993; Schmidt, 2002). These ideas speak to how policies offer solutions to the problems at hand, how programmes define the problems to be solved, and how both policies and programmes mesh with the deeper core of principles and norms of relevant scientific disciplines or technical practices. Normative ideas instead attach values to political action and serve to legitimate policies through reference to their appropriateness.

Normative ideas speak to how policies meet the aspirations and ideals of the general public and how programmes and policies resonate with a deeper core of principles and norms of public life, whether newly emerging values or long-standing ones (Schmidt, 2002).

The big question for scholars of ideas has been why some ideas become the policies, programmes, and philosophies that dominate political reality while others do not (Schmidt, 2008). The standards and criteria they propose for evaluating ideas tend to identify a range of political scientific factors that help explain why specific policies may succeed and why they change. Here, policy success is concerned with the specific criteria to ensure the adoption of a given policy. Hall (1989) speaks of the need for policy ideas to have administrative and political viability in addition to policy viability (see also Kingdon, 1995; Cox, 2001). Programmatic and philosophical ideas tend to offer more general theories about ideational success (e.g. Jobert, 1989; Majone, 1989; Hall, 1993), linked not only to the viability of policy ideas but also to the programme's long term problem-solving potential. The success of a programme depends on the presence of cognitive ideas that a given programme will provide robust solutions, but also the presence of complementary normative ideas that those solutions also serve the underlying values of the polity.

Commonly referred to as a competitive 'marketplace for ideas' (Schlesinger, 2003), the study of ideas across healthcare systems is not new (e.g. Beland, 2010; Bhatia and Coleman, 2003). As Beland states, leading scholars who theorise the construction of policy issues and problems have often referred to healthcare policy to illustrate their broad analytic claims (Stone, 1997; Kingdon, 1995). For example, Hacker (1997) explicitly borrows from Kingdon's work to explain why and how healthcare reform became a key policy issue in the United States at the beginning of the 1990s. The study of ideational assumptions has also proven useful for studying healthcare policy (e.g. Beland and Hacker, 2004). Ideas have provided a powerful framing device to legitimise particular policy decisions in making a case for reform (Beland, 2007; Schon and Rein, 1994; Schmidt, 2002). Bhatia and Coleman (2003) point to the central role of framing processes in policy change across Germany and Canada. Hacker (2006) outlines how in the United States the existence of widely shared policy assumptions delayed major legislative reforms, as decision makers tended to perceive new and possibly transforming social and economic trends as inconsequential. Jacobs (1993) also points to the role of culture and public opinion in framing U.S. and British healthcare reform.

Traditionally, such analysis of ideational success have used methods based on comparative case studies and “process-tracing” to demonstrate how ideas are tied to action and serve as guides to actors for what to do (see Berman, 1998; Blyth, 2002). Whilst these approaches have produced landmark studies in the area, recent attention to ideas has focused on their types and forms as ‘the substantive content of discourse’ (Schmidt, 2008). This perspective argues that discourse is a resource used by actors to produce, legitimate and convey ideas bringing new values, rules and practices. Discourse exerts a causal influence by promoting change in terms of its representation of ideas and as the discursive process by which it conveys those ideas. In line with Schmidt’s conception of ideas, our interest is also in the process by which ideas are conveyed, adopted, and adapted. The study of ideas represented in discourse and the interactive processes by which ideas are conveyed can help explain why certain ideas succeed and others fail. The manner in which ideas are projected can take different formats (e.g. narratives, frames, stories, scenarios, images) and the discourse articulating ideas can also differ in projected audience and location.

Schmidt (2008) suggests this discursive interaction often appears to go from the top down. Policy elites generate ideas, which political elites then communicate to the public. Political elites often interweave the coordinative (the individuals and groups involved in the creation and justification of policy and programmatic ideas) and communicative discourses (the individuals and groups involved in the presentation, deliberation, and legitimation of political ideas to the public) to present a coherent political programme. The NSR provides an example of such discursive interaction. Here, Lord Darzi acted as the political elite in charge of communicating the reform proposals to NHS staff. The representation of ideas was dependent on the ability of Lord Darzi to communicate how the NSR reform proposals represented a bottom-up response to the needs of NHS staff. Furthermore, it was based on the ability to involve and engage clinicians by drawing on his own experience as a ‘doctor not a politician’ (Department of Health, 2007: 3). It is an example of how political elites combine coordinative and communicative discourses into a coherent reform programme.

As with other approaches, Schmidt (2008) suggests ideational success or failure of policy programmes like the NSR will depend on relevance to the issues at hand in terms of adequacy, applicability, appropriateness, and resonance. It will also depend on consistency and coherence across policy sectors, although vagueness or ambiguity is important. The formal institutional context impacts on where and when discourse may succeed,



resonating with audiences at the right times in the right ways, convincing in cognitive terms (justifiable) and persuasive in normative terms (appropriate and/or legitimate).

Our analysis of ideas is situated within Schmidt's conception of discursive institutionalism. This has a primary concern with how ideas are communicated through discourse and the institutional contexts in which this communication takes place (Schmidt, 2011: 51; Schmidt, 2008; Hay, 2011). Institutions are simultaneously constraining structures and enabling constructs internal to agents whose 'background ideational abilities' explain how they create and maintain institutions. These background ideational abilities underpin agents' ability to make sense in a given context; that is, the ideational rules or rationality of a given discursive institutional setting (Schmidt, 2011: 55). At the same time, Schmidt suggests that it is their 'foreground discursive abilities' that enable them to communicate critically about those institutions, to change or maintain them (Schmidt, 2008). The purpose of empirical analysis is therefore to show how ideas are generated, debated, adopted, and changed as policy makers, political leaders and the public are persuaded or not of the cognitive necessity and normative appropriateness of ideas (Schmidt, 2011: 57).

## **Methods**

Our focus on the ideas associated with delivering the NSR was built on a series of semi-structured interviews with actors working within the English NHS. It formed part of a national evaluation of the combined impact of health reform in England within six regions (see Powell et al., 2011). This carried out a series of semi-structured interviews with those leading the delivery of healthcare policy reform within the English NHS between 2008 and 2009. The sample comprised a variety of primary and secondary care organisational roles that included chief executives, directors of operations, strategy, medical directors, lead clinicians, consultants of specialities and general practitioners. These actors were identified in order to obtain the perspective of organisational leaders, experts and locally identified knowledge brokers who had an understanding of how health reform had impacted locally on their organisation and their profession. A total of 215 semi-structured interviews were undertaken (see Powell et al., 2011). This article uses a sample of these interviews with actors who were located in organisations and clinical settings where the NSR was mentioned as a policy reform being implemented (n ¼ 126). All these interviews were recorded and transcribed.

The NVivo computer software programme was used to manage and support the data analysis process.

Data analysis of the NSR was informed by current thinking about analysing ideational processes that draws on the concept of framing (Bee land, 2009: 705). As with Bhatia and Coleman in their study of policy ideas, policy frames are defined as 'coherent systems of normative and cognitive elements which define, in a given field, "world views", prescriptions and practices for actors subscribing to the same frame' (Surel, 2000: 496). Frame analysis shares the interpretive idea that individuals hold frameworks of interpretation defining how cognitive categories operate to organise, shape, and classify experiential material to make it meaningful (Benford and Snow, 2000). This has been popularised by Schoon and Rein's (1994) view that sees policy positions resting on underlying structures of belief, perception and appreciation, directing attention toward particular features and away from other features. In this respect, policy frames constitute fields of action within which policy problems are conceived and choices about policy strategies are made (Wendt, 1999: 78). The successful adoption of a new policy frame will depend both on the normative and cognitive content of the frame and on the process by which it is framed.

Identifying these policy frames began in the transcription and coding process. In order to obtain the ideas about the NSR, we focused on the stories that were associated with its delivery, paying close attention to the sequence of events, experiences, or actions associated with the NSR (Czarniawska, 1998). Like others (e.g. Feldman et al., 2004) we believed such narrative form is important in revealing what is significant to people, providing a vehicle for understanding their ideas. This analysis of narratives associated with NSR did not extend to logic and semiotics but was a process of inductive and iterative thematic coding. From reading and re-reading these passages of text it became apparent that there were four distinctive policy frames associated with the NSR. These highlighted different forms and types of ideas related to policy change, policy continuity and policy conflict. In looking to cluster these policy frames, the team proceeded to label the different frames to effectively capture these ideas. A process of deliberation ensued and it was agreed that the different ideas associated with the NSR framed the policy proposals as "progress", "prevailing policy", "prescription" and "professional disputes" (with alliteration intending to add additional effect). This process excluded instances where actors were not familiar with the NSR and could therefore not comment on how it was being delivered.

**Ideas about healthcare reform**

Different ideas framed how the NSR was being delivered. Our first frame of the NSR revealed a degree of ideational success in supporting the policy changes in recognition of its problem solving potential: the idea of progress. The second frame also revealed a degree of ideational success in support for the NSR based on the belief that the policy ideas were already being delivered: the idea of prevailing policy. The third frame revealed policy conflicts in outlining the contextual difficulties in delivering the policy proposals: the idea of prescription. The fourth frame also revealed policy conflict related to the NSR construction of clinical involvement and engagement: the idea of professional disputes (see Table 1).

Table 1. Ideas about the Next Stage Review

Framing policy reform	Ideas about the Next Stage Review	Implications for ideational success and failure
Progress	Ideas in relation to quality and clinical engagement represented progress in the reform agenda, replacing previous emphasis on structural reorganisation and performance targets.	Evidence of ideational success as policy constructed a reform imperative focused on qualitative experience.
Prevailing policy	Ideas related to quality improvement, clinical engagement and community-based services represented continuation of existing activity.	Evidence of ideational success as it framed solutions to policy problems in normatively acceptable terms. NSR represented a bricolage of ideas that combined with existing beliefs and legitimate concepts within institutional environments.
Prescription	Ideas about improving access to primary care services reflected a top-down view of policy.	Evidence of ideational failure concerning cause-and-effect relationships underpinning NSR. The policy blueprint challenged by local discretion in reinterpreting policy

imperatives.

Professional  
disputes

Ideas about clinical engagement challenged by primary care audiences as the worldview of healthcare systems narrowly shaped by Lord Darzi as a London-based surgeon.

Evidence of ideational failure as inter-professional relationships and conflict indicative of the system of professions in healthcare that compete for jurisdiction, and the exclusive scope of practice. Attempt to claim jurisdiction struggled due to existing understandings of clinical practice and primary care more generally.

### *The idea of progress*

Our analysis of the NSR identified evidence of ideational success in the way that actors supported the adoption of its policy proposals. The perspective of those actors predominately occupying director-level positions in hospitals and primary care organisations conveyed large degrees of support for the policy proposals. Here the NSR represented progress in promoting a policy change calling for a greater emphasis on quality improvement and the promotion of clinical involvement in the reform process. These were rather normative ideas supporting the principle of the policy reform that placed emphasis on quality improvement of the healthcare system. The NSR represented progress in moving the healthcare reform agenda away from the existing emphasis on top-down performance measurement towards greater emphasis on quality:

*What Darzi brings for me is the ability to move beyond the dictat top target, into really driving the visionary stuff for yourself.... Actually it is a much more permissive, qualitative agenda that you should be able to exploit. (Foundation Trust [FT] Chief Executive 1)*

*We needed something like the Darzi report to come out because how much had we really commissioned for quality, question mark. (Primary Care Trust [PCT] Director of Information)*

These ideas about the NSR as progress were also in support of the need to move reform efforts away from further structural reform.

*I think it's an evolution that's basically saying yes we put a lot of structural work in, but we now need to start looking at outcomes and quality and we're not therefore saying loads more structural reform needs to take place. (FT Medical Director)*

*I think Darzi's moving towards there are givens now, aren't there, there are givens around, you won't be waiting three years to have your hip done anymore. So we've done that, that's part of the normal service, what we need to do now is make sure that the quality and the experience is absolutely the best it can be. (FT Director of Nursing)*

Alongside ideas about the NSR promotion of quality, these actors also believed that the emphasis on clinical engagement within the reform proposals symbolised progress in healthcare reform. By emphasising clinical engagement in the reform process, the NSR symbolised progress from previous reform efforts by encouraging greater involvement of professional staff:

*I do welcome this drive towards clinical engagement. I mean, I've been doing clinical engagement the whole of my ten years career in management and it's never been an easier time to do it.... Lord Darzi has persuaded everybody that clinicians do need to be involved at every level and you must do it. So that's got to be a good thing. (PCT Medical Director)*

In these boardroom institutional settings, these ideas demonstrated an example of how the policy programme had administrative and political viability, in addition to policy viability, to facilitate successful adoption (e.g. Hall, 1989). The NSR therefore succeeded in resonating with these audiences, the programme was convincing in providing policy solutions and persuasive in gaining support for the underlying values to the proposals. The proposals had problem-solving potential based on being relevant to the issues at hand.

### **The idea of prevailing policy**

Our analysis of the NSR demonstrated further evidence of ideational success as it framed solutions to policy problems in normatively acceptable terms. The idea of prevailing policy was evident in the way NSR represented a bricolage of ideas that combined with existing beliefs (Campbell, 1998). The policy proposals were recombined with existing legitimate concepts within institutional environments. For example, actors from both primary and secondary care organisations suggested that the reform proposals were

already being delivered within existing local policy agendas. Within these contexts, policies built around quality improvement, clinical engagement and developing community based services existed prior to the NSR.

*I suppose a lot of the stuff that we have been doing pre Darzi was very much endorsed by what he was saying really in terms of moving services out of hospital, particularly with diabetes and having services closer to home the patients, you know, we have been doing that anyway. So it's not been a huge change. (PCT Diabetes Consultant)*

*I think you know the strength of the Darzi.... It didn't bring out a plethora of new initiatives.... In a way it pretty much feels part and parcel of what we're trying to take forward anyway. (PCT Director 3)*

Actors in secondary care also made the connection between the NSR reform proposals and policy continuity. For example, some suggested that reform delivering greater clinical engagement in hospital-based settings was already underway:

*The Darzi mantra about clinical engagement and so on... it's not new to us so we haven't taken any of this as seriously as we ought to because it's almost like 'well it's not a lot new in Darzi and Next Stage Review for us'. (FT Chief Executive 2)*

These examples show how actors framed the NSR proposals as an attempt to modify and recombine existing institutional elements in new and socially acceptable ways (Campbell, 1998; Douglas, 1986). There is evidence of success as ideas related to quality improvement, clinical engagement and developing community based services coincided with existing activities. Rather than a cognitive guide, the NSR represented a normative idea. It legitimised existing programmes and signalled support for the existing policy direction.

### *The idea of prescription*

The ideas of progress and prevailing policy illustrated broad normative support for the NSR proposals. Our analysis of the NSR also identified cognitive ideas associated with particular policy solutions. These ideas presented alternative frames of the NSR that challenged its bottom-up view of implementation in responding to local needs and contexts with an image of policy that was top down: a mechanical process built around central authority, and ordered in a hierarchical manner specifying responsibilities and tasks. Those delivering clinical services in primary care settings presented the NSR as highly prescriptive. These prescriptive elements centred on its policy proposals

to improve access to primary care—in particular, the creation of intermediate care centres also referred to as “polyclinics”.

*Darzi is a real, I suppose, political cat among the pigeons, in some areas. I think his reforms are based on a lot of thinking and hard work that's gone on, looking at how to reform general practice.... I think it was done in a very specific area. I think the initial looking at things like polyclinics was done in an area of London which was under-doctored, certainly it has created a huge political stink locally here, because it's been seen as having to be delivered by a Primary Care Trust that is distant from the population of GPs it covers, and been driven through without asking them. (GP 4)*

Within this critique of the reform proposals was the belief that such prescription was not sensitive to local geographical factors. The policy was shaped by an interpretation of what was needed for London but not relevant elsewhere in the country. For example, a chairman of a primary care committee (who was also a general practitioner) believed that the reform proposals symbolised a narrowly defined view of primary care based on Lord Darzi's personal experience of working in London.

*He came to... in the process of his review and said 'this is a polyclinic, this is exactly what I've been talking about for the last year or so' to which I said 'Lord Darzi, we've had these in... for about a hundred years, we just call them community hospitals down here, and that's got a GP practice on site, that particular hospital it's a modern facility, it has outpatients, it has an operating theatre, it has inpatients, so it is to all intents and purposes a Darzi clinic'.... We run all the services in those units that he wants to see in his Darzi set up... so it works well in London where you've got a concentrated population centre you then have a viable population base to make sure that your clinics are full. We don't have that in...because they don't have the volume from the population to make it worthwhile. (GP 3)*

These ideas challenge the cause-and-effect relationships underpinning NSR policy action. Here the policy solutions of the NSR related to improving primary care services were in tension with local contexts. Policy solutions promoting polyclinics evoked cognitive ideas that reacted to the proposals, but were also used as a justification for existing policies and programmes, as these were contextual appropriate to the principles and norms of existing institutions. This draws attention to the deeper level of ideas, how existing paradigms can constitute broad cognitive constraints on the range of solutions

that actors perceive and deem useful for solving problems (Campbell, 1998). Furthermore, these ideas highlight how local institutions can possess some discretion and latitude in reinterpreting national policy imperatives according to organisational contexts and individual attitudes. In drawing attention to the implementation gap, local practitioners and agencies had the potential to undermine the spirit and the purpose of central policies (Lipsky, 1980; Exworthy et al., 2003).

### *The idea of professional disputes*

The idea of professional disputes presented an additional frame that challenged the NSR proposals. These ideas illustrated how actors selected symbols and concepts to highlight how NSR challenged particular values. In particular, they showed how NSR represented an attempt to manipulate conceptions of clinical engagement and representation. Those working in primary care, particularly general practitioners, presented ideas about the NSR that specifically focused on the professional background of Lord Darzi as surgeon in a London teaching hospital. They questioned the reform proposals based on Lord Darzi's clinical background as a surgeon on the basis that such a perspective gave a myopic view of local healthcare systems.

*I did wonder why a surgeon has been asked to develop reforms in primary care. With due respect to the surgeon involved anybody outside of the realm of doctor, he doesn't seem to perceive as a clinician. And I think that's an ideological problem that he's got that he needs to sort out really. (Nurse Consultant)*

*...I have to say, being very honest, I don't think Darzi understands commissioning and I don't think he understands what PCTs [commissioning organisations] do and to some extent why should he, he's a surgeon. (PCT Director of Strategic Commissioning 2)*

*I'm sure he's a bloody good surgeon or was a bloody good surgeon, but there's no real sort of clinical input into these Darzi visions.... I met Darzi when he came up to last year. He didn't have a clue what was going on. He didn't understand what an independent contractor GP was. This guy was reorganising general practice. He couldn't see the fundamental difference between us as GPs running our own practices, being independent contractors and a large private run company like United Health running a practice. (GP 2)*



Despite presenting the policy reforms as sensitive to clinical needs by involving clinicians in the reform process, these beliefs challenged the policy claims of a review built on clinical engagement. More specifically, both general practitioners and those in primary care more generally believed that the reform proposals were limited by a worldview that was based on a surgeon working in an acute care setting. This worldview did not reflect their professional or clinical identity, particularly for those working in primary care settings. As a result, the policy proposals were believed to be problematic in having a marginalising effect on those delivering primary care services. These were normative ideas that attached values to political action and questioned the legitimacy of policies through reference to their appropriateness (March and Olsen, 1989).

These normative ideas also speak to how programmes and policies resonate with a deeper core of principles and norms of being a clinician. Such ideas are illustrative of how policies with highly salient symbols can often produce high levels of conflict (Matland, 1995). Such inter-professional relationships and conflict are indicative of the 'system of professions' in healthcare that compete for jurisdiction, and the exclusive scope of practice (Abbott, 1988). Lord Darzi leading reform was an attempt to claim a jurisdiction by appealing to the clinical audience (Abbott, 1988: 59). When appealing to these audiences, professional groups draw on dominant cultural norms to support and justify their claims to expertise and authority within a specified area of social life. In this case, it showed how the attempt to claim jurisdiction struggled due to existing understandings of clinical practice and primary care more generally (Adams, 2004).

### **Delivering healthcare reform: Ideational success and failure?**

The NSR was associated with different ideational frames that were generated, debated, adopted by actors in the delivery of healthcare services. The findings presented above show how actors were either persuaded or not of the cognitive necessity and normative appropriateness of the NSR. By drawing attention to such ideational success and failure we can go some way to explaining why certain ideas succeed and others fail because of the ways in which they are projected to whom and where. Evidently the pinning down of policy success remains an ongoing issue (Marsh and McConnell, 2010), however by drawing attention to these ideas we can help to explain why certain policies succeed and fail but also why they change.

The evidence of ideational success in relation to the adequacy, applicability, appropriateness, and resonance of the NSR draw attention to the reform

programme's long term problem-solving potential. Ideas about policy progress reveal how the NSR was successful in constructing a reform imperative built around quality improvement and clinical engagement. Ideas about prevailing policy brought to the fore how the NSR became part of the bricolage of existing ideas and institutional arrangements. Both the idea of progress and of prevailing policy provide instances of formal institutional context where the NSR was more likely to be successfully adopted. In these contexts its organising ideas, values, and principles resonated with audiences. The NSR in this sense had normative appeal in attaching values to political action and legitimate policies by reference to their appropriateness.

However, the evidence of ideational failure. Displayed how institutional contexts acted as constraining structures and enabling constructs to agents in relation to the NSR (Schmidt, 2011: 55). The idea of prescription highlighted how the NSR was not convincing in cognitive terms, particularly in relation to the development of new primary care centres (polyclinics) across different contexts. This evoked a reaction to proposals that justified existing policies and programmes more contextually appropriate to the principles and norms of existing institutions. More discretion and latitude in relation to the NSR proposals was needed. The idea of professional disputes highlighted how the NSR was not convincing in normative terms. Here, Lord Darzi symbolised a divisive figure as a London-based surgeon who did not represent other clinical professions, particularly those working in primary care settings. These proposals resonated with a deeper core of principles and norms governing healthcare professionals in claiming jurisdiction and scope for practice.

We highlighted earlier how policy frames define 'coherent systems of normative and cognitive elements which define, in a given field, "world views"', prescriptions and practices for actors subscribing to the same frame' (Surel, 2000: 496). The successful adoption of a new policy frame will depend both on the normative and cognitive content of the frame and on the process by which it is framed. Here, success does not just depend on the presence of cognitive ideas that a given programme will provide robust solutions; it also depends on the presence of complementary normative ideas that those solutions also serve the underlying values of institutional contexts (Schmidt, 2008). These findings show the extent to which the NSR persuaded actors that both the cognitive necessity and normative appropriateness of ideas was limited. There was success in particular boardroom institutional contexts but failures in primary care settings and across clinical groups, particularly general practitioners.

In this sense, the NSR was unable to communicate its package of ideas successfully across different institutional settings. Certain ideas failed because of the ways in which they were projected to whom and where. What is particularly interesting about the NSR is that despite Lord Darzi being presented as a political elite able to communicate the reform proposals to NHS staff, his message proved to be unsuccessful in combining the coordinative and communicative discourses into a coherent political programme amongst different clinical groups and primary care professionals more broadly. These groups were not persuaded of either the cognitive necessity or normative appropriateness of these ideas.

This analysis of reform policy illuminates the continuing difficulties of communicating these policy ideas. This failure of the NSR to persuade at both cognitive and normative levels is perhaps illustrative of why these ideas to improve quality, move care into community settings and involve clinical leaders in healthcare settings continue to be of relevance. For example, in a recent letter to NHS staff about future policy in the NHS, Health Secretary Andrew Lansley (2012) stated that

*the Health and Social Care Act will, in reality, empower NHS clinicians to determine the type of health services needed in their local area, using their clinical expertise and their knowledge to ensure NHS services meet the needs of patients.*

*My ambition is for a clinically-led NHS that delivers the best possible care for patients. Politicians should not be able to tell clinicians how to do their jobs.*

Clearly, there is still work to be done by both the policy and political elites in presenting and legitimating such ideas as a coherent reform programme.

### **Concluding remarks**

This article has presented an ideational perspective about delivering policy reform in English healthcare. By utilising the study of ideas within the dynamics of discourse, the findings suggest that despite policy intentions and the efforts of policy entrepreneurs, the interaction between ideas and institutions meant varying degrees of ideational success and failure. Whilst acknowledging that the interpretation is susceptible to being overly deterministic and idealistic, it presents a contribution to understanding about the ideas that matter to actors in healthcare settings as they navigate policy reform. The perspective has the potential for giving new insights into the

long-standing disagreements between medicine, management, policy makers and the professions, and how different actors in healthcare frame policy in different ways across different institutional settings.

A limitation of the analysis has been that we have not been able to analyse these ideas over time or in the changing circumstances (Bee land, 2010: 627). Furthermore our case of reform captures a particular agenda at a particular point in time. The NSR proposals have now been superseded by a new Health and Social Care Act 2012; however, while this has the potential to introduce a new and distinctive reform programme, our analysis suggests the ideas central to the NSR still resonate and form a key component of current thinking about healthcare reform.

When reflecting on the NSR, these findings draw attention to the difficulties for political elites to successfully interweave the coordinative and communicative discourses into a coherent political programme. The case of Lord Darzi shows how policy entrepreneurs can only go so far and that alternative framings of policy within institutional settings inevitably shape how policies are delivered. To achieve ideational success, perhaps greater sensitivity by policy and political elites to these alternative framings is something worth considering.

## **Note**

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